

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION

LICENSE APPLICATION/RENEWAL REQUEST
FOR COMMUNITY HOMES FOR PERSONS WITH DEVELOPMENTAL OR PHYSICAL DISABILITIES

Name of Corporation

Name of Community Home

Corporation Mailing Address

Community Home Address

City State Zip Code

City State Zip Code

Corporation Telephone

Community Home Telephone

Executive Director

Community Home Manager

License Application for (check one):

() Community Home for Persons with Developmental Disabilities

() Community Home for Persons with Physical Disabilities

Total Number of Residents _____ **Male** () **Female** ()

Provider: PLEASE CHECK IF ITEM IS ENCLOSED WITH THIS APPLICATION OR WRITE IN THE DATE WHEN THE ITEM *HAS BEEN* OR *WILL BE* SENT TO THE DEPARTMENT.

Date or ✓ New Applicant			Date or ✓ Renewal Applicant		
		Fire Marshal Inspection or date scheduled			Fire Marshal Inspection or date scheduled
		Sanitarian Inspection or date scheduled			Sanitarian Inspection or date scheduled
		Articles of Incorporation and Bylaws			Major changes to Articles of Incorporation
		Organizational Chart			Major Changes to Organization Chart
		Copy of Insurance Coverage			Copy of Insurance Coverage
		Personnel and Program Policies and Job Descriptions for each position			Major changes to Personnel or Program Policies
		Board structure and composition with names, addresses and terms of memberships			Board structure and composition with names, addresses and terms of memberships

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PLEASE COMPLETE THE FOLLOWING FOR EACH FULL TIME, PART TIME AND RELIEF STAFF MEMBER

Name	Position	Date of Hire	Med. Cert Date	Orientation Hours	Annual Training Hours	Restraint Training Date	First Aid Training Date

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION GIVEN TO THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ON THIS APPLICATION IS TRUE AND CORRECT.

Executive Director or Manager

Date